

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2025
NAME OF PROVIDER OR SUPPLIER Noble Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 North 8th Street Noble, OK 73068	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Some	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents were free from abuse for 4 (#1, #2, #3, and #4) of 4 sampled residents reviewed for abuse.</p> <p>The DON identified 81 residents resided in the facility.</p> <p>Findings:</p> <p>A policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property, reviewed 02/12/20, read in part, Residents must not be subjected to abuse. neglect, exploitation, misappropriation of resident's property by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, resident representative, friends or other individuals.</p> <p>1. Resident #1's Quarterly MDS assessment, dated 06/20/25, showed they had a BIMS score of 13 indicating they were cognitively intact.</p> <p>On 06/24/25 at 9:43 a.m., Resident #1 stated, I just witnessed [Resident #5] hit other people. They took [Resident #5] somewhere else, [Resident #5] does not live here anymore.</p> <p>2. On 06/23/25 at 1:17 p.m., Resident #2's left ear was observed with dried blood on it. There was an approximately 1 cm scratch on the top of the [NAME] (ear). Resident #2 stated all staff did was put Betadine (antiseptic) on it. Resident #2 takes Eliquis (an anticoagulant) 5 milligrams every 12 hours.</p> <p>Resident #2's Quarterly MDS assessment, dated 06/13/25, showed they had a BIMS score of 12 indicating they were moderately cognitively impaired.</p> <p>On 06/23/25 at 1:17 p.m., Resident #2 stated Resident #5 came up to me twice and started hitting me as hard as [they] could in the head. Resident #2 stated Resident #5 beats on anybody that [they] can get away with it. Resident #2 stated staff told Resident #5 to go to their room. Resident #2 stated, Don't want to kill anybody, but [Resident #5] makes me want to kill [them].</p> <p>3. Resident #3's Quarterly MDS assessment, dated 06/07/25, showed they had a BIMS score of 8 indicating they were moderately cognitively impaired.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/23/25 at 2:27 p.m., Resident #3 stated, When [Resident #5] was yelling at me, [they] spit in my face. I told the officer that was assault. The officer said eventually I would get a summons in the mail and would have to go to court regarding trying to press charges. Unfortunately I couldn't walk or I would have hit [Resident #5]. Staff split us up. Nothing else happened. [Resident #5] still looks at me like [they] wants some trouble. [Resident #5] goes around behind me when I am sitting down and bumps into my chair on purpose. [Resident #5] is just a bully. If it comes down to it, I will cripple [Resident #5].</p> <p>4. Resident #4's Quarterly MDS assessment, dated 05/04/25, showed they had a BIMS score of 12 indicating they were moderately cognitively impaired.</p> <p>On 06/23/25 at 2:22 p.m., Resident #4 stated they were scared to death of [Resident #5] and [Resident #5] needs to be somewhere else. I hate [Resident #5].</p> <p>5. On 06/23/25 at 3:34 p.m., during the interview of Resident #5 outside in the smoking area, with their 1:1 staff present, other residents started coming out for their timed cigarette break. Resident #5 started pointing out people saying that piece of [expletive] right there in the red hat. Resident #5 proceeded to call another resident a fat [expletive], fat piece of [expletive], faggot amongst other derogatory terms. Resident #5 then yelled Shut up when residents started telling Resident #5 to stop talking to them like that. Resident #5 stood up, shaking with rage so badly that they spilled coffee on surveyor. Resident #5 then started slamming their walker onto the ground repeatedly while continuing to yell expletive words at staff and other residents. Resident #5 came towards male staff who was attempting to get Resident #5 to calm down. Resident #5 had their hands balled up in fists yelling right into male staff members face. No staff touched Resident #5 at all, they simply stood between Resident #5 and the other residents trying to get Resident #5 to calm down. Seven staff members came outside to try to de-escalate the situation . The staff had to send in the residents that were coming out to smoke.</p> <p>On 06/23/25 at 3:39 p.m., once the other residents had went back inside, Resident #5 started yelling at the only other resident that remained outside, and banging their walker around. The DON and administrator arrived to the scene and at 3:40 p.m., the administrator called the police and asked them to get there as soon as possible. Multiple staff members created a barricade with their bodies around the other resident while one staff walked with Resident #5 to their room. Resident #5 was yelling and cussing the entire way to their room.</p> <p>On 06/23/25 at 3:44 p.m., two police officers arrived to speak with staff and Resident #5.</p> <p>Resident #5's admission MDS assessment, dated 04/23/25, showed they had a BIMS score of 15 indicating they were cognitively intact.</p> <p>An Incident Report, dated 06/09/25, showed Resident #1 accidentally ran into Resident #5's walker, causing Resident #5 to grab Resident #1's arm. Resident #2 then stated come and get some to Resident #5. Resident #5 then proceeded to hit Resident #2 in the head. Staff split the residents up. Medications were changed for Resident #1 and #5, Resident #2 was sent out to ER with no injury found.</p> <p>On 06/16/25, an Abuse policies and procedures staff in-service was completed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>An Incident Report, dated 06/19/25, showed Resident #5 closed the blinds in the dining room due to the glare, and Resident #3 yelled at Resident #5 to open the blinds back up. Both residents started yelling at each other and then Resident #5 spit in Resident #3's face. Resident #3 then wanted to press charges. Police were called. Residents were separated. A mental health physician was contacted. A mental health agency scheduled de-escalation in-service with staff.</p> <p>On 06/20/25, a QAPI (Quality Assurance and Performance Improvement) behavior sheet was initiated, and it has continued to be updated with each behavior and the interventions.</p> <p>An Incident Report, dated 06/22/25, showed Resident #5 started yelling and hitting Resident #2 in their left ear. Resident #5 also pushed their walker against Resident #4's wheelchair causing it to roll backwards. Staff split up the residents. Resident #2's ear was treated, Resident #4 had no injury, and Resident #5 was put on 1:1.</p> <p>On 06/23/25 at 3:12 p.m., Resident #5 stated, I am an easygoing person to get along with. I am not going to be a captive audience to these idiots. [Resident #2] threatened me four times and came at me and I hit [Resident #2] upside the head. [Resident #2] could have easily went around. Satan [referring to Resident #1] started coming in to bingo when it was almost over staff put [Resident #1] out and when [Resident #1] came back in, I wanted [Resident #1] to leave. [Resident #1] came over and rammed their wheelchair into me again. Later when I was coming back in from smoking [Resident #2] said something like 'what makes you special.' I followed [Resident #2] and asked what is your problem? They said 'you are.' I started wailing on [Resident #2] again. The sun was shining on me and I went to shut the blinds and [Resident #3] started screaming at me. I went and asked why are you yelling at me? [Resident #3] also screams at staff. [Resident #3] told me they were going to take care of the problem. That is when I spit on [Resident #3] and started screaming to call the police. A police officer did come. I have been on 1:1 before it might have been the other time. Today I am sitting with the person doing the 1:1, and a dietary person said 'what floor are you on' and [the 1:1 staff] said I'm right here, and the dietary person said 'exactly.' I asked the [1:1 staff] if it was directed at me and they said they didn't know what it was about. I said [to the dietary person] 'do you have something to say because I don't want to think you are a sissy' and if I see [dietary staff] looking at me I am going to go after them.</p> <p>On 06/23/25 at 3:29 p.m., Resident #5 stated [the DON] told me I could either go to jail or the hospital, so I packed and got ready to go to jail. The officer told me, I wasn't going to jail. [The DON] said 'I'm not sending you to jail, if is your behavior that is sending you to jail.' I packed again today for wherever they want to send me. They have my finances tied up so when I do leave I wont have my social security.</p> <p>On 06/24/25 at 11:42 a.m., licensed practical nurse #1 stated, [Resident #5] refused care a lot. [Resident #5] had an altercation with a resident and spit on them. We separated them and tried to take [Resident #5] to their room to calm down. Sunday [Resident #5] had an altercation with other residents and when I tried to get [Resident #5] to go to their room, they rammed into a different resident unprovoked. [Resident #5] got in my face and told me 'I was going to my room already.' When I was here, I did not feel [Resident #5] was provoked in any way, but [Resident #5] told me if they felt threatened they would fight. That day we also initiated the 1:1 and [Resident #5] would be mad that someone had to sit with them.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	<p>On 06/24/25 at 10:30 a.m., the administrator stated they have been in contact with the physician, the psychiatric physician, a mental health agency, the police, and tried multiple interventions. The administrator stated Resident #5 signed against medical advice papers and left with the cops on 06/23/25 at 4:15 p.m., after telling staff it was none of their business where they (Resident #5) went.</p> <p>On 06/24/25 at 12:15 p.m., the DON stated, Law enforcement was called and they said they cant take [Resident #5] to jail unless they are actively abusing someone when the cops arrive, and to press charges, it has to go to the DA [district attorney] first. I don't know what else we can do.</p>		